SECTION B - MORE INFORMATION ABOUT YOU

1) Are **YOU** now getting any medical services related to an illness or injury which occurred on the job for which **YOU** have or will file a workers' compensation claim?

YES ☒ **NO** ☐ If **YES,** Date of Illness or Injury: 03 (M M) – 19 (D D) – 2000 (Y Y Y Y)

If **YES,** Insurer Name

WEALTH PLUS

ADDRESS

29 MAIDEN LANE

ADDRESS

CITY: PEEKABOO STATE: NY ZIP: 41789

2) Are **YOU** now getting any treatment for an illness or injury for which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance ?

YES ☒ **NO** ☐ If **YES,** Date of Illness or Injury: 01 (M M) – 05 (D D) – 1997 (Y Y Y Y)

If **YES**, Insurer Name

PRESTIGE HEALTH

ADDRESS

550 PARK AVE

ADDRESS

CITY: PEEKSKILLS STATE: NY ZIP: 74036

Your Signature Is Required

Theodore Public

AREA CODE PHONE NUMBER 401 – 985 – 8432

OMB NO. 0938-0214

SAMPLE